MEDICAL MANAGEMENT

Molina Healthcare Providers must ensure Members receive medically necessary health care services in a timely manner without undue interruption. The Member's PCP is responsible for providing routine medical care to Molina Healthcare Members, following up on missed appointments, prescribing diagnostic and/or laboratory tests and procedures, coordinating referrals and obtaining prior authorization when required.

This section on Referrals, Authorizations, and Utilization Management (UM) describes procedures that apply to directly contracted Molina Healthcare PCPs. All contracted Providers must obtain Molina Healthcare's authorization for specific services that require prior approval, unless the requesting Provider is affiliated with a medical group/IPA granted "delegated" Utilization Management status (For information on contracted medical groups/IPAs that are delegated for UM please see the Medical Group/IPA Operations section of this manual). If you are treating a Member assigned to a PCP in one of the delegated medical groups/IPAs, Molina Healthcare Providers are required to follow their specific authorization requirements, as they may restrict their referrals to Providers within their group.

For technical assistance providers can contact Molina for assistance in finding appropriate network specialist based on your patients needs including behavioral health, substance abuse and developmental issues. We can also assist in scheduling exams.
You can contact the Healthcare Services Department at: (800) 869-7185

UTILIZATION MANAGEMENT – REFERRAL PROCESS

Prospective review is a process performed by the UM staff to evaluate referrals for specified services or procedures. Determinations are made by licensed review nurses, based on medical necessity and appropriateness, and reflect the application of Molina Healthcare's approved review criteria and guidelines. Any denial of services may only be issued by the Medical Director (except for services denied because of benefit limitations).

Referral versus Prior Authorization: Referrals are made when medically necessary services are beyond the scope of the PCP's practice or when complications or unresponsiveness to an appropriate treatment regimen necessitates the opinion of a specialist. In referring a patient, the PCP should forward pertinent patient information/findings to the specialist. Except for some benefits such as routine eye exams and women's health care needs, Members are required to obtain referrals from their PCPs for specialty care services. Specialists may refer Members to other specialists or for ancillary services. Referrals and authorizations do not have to be routed back through the PCP. **Only certain services require a prior authorization from Molina Healthcare for payment of claims. These services are listed on the WebPortal Prior Authorization by CPT code guide.**

Generally, prior authorization requirements are designed to assure the medical necessity of service, prevent unanticipated denials of coverage, ensure participating Providers are utilized and all services are provided at the appropriate level of care for the Member's needs.

Providers should send requests for prior authorization to the Healthcare Services Department by WebPortal, phone, fax, or mail, based on the urgency of the requested service. We request that when possible authorization requests are submitted via the WebPortal. Contact information is listed below.

WebPortal:	**https://eportal.molinahealthcare.com/Provider/login**
Phone:	**(800) 869-7185**
Fax:	**(800) 767-7188**
Advanced imaging only Fax:	**(877) 731-7218**
Mail:	**Molina Healthcare of Washington, Inc.** **Attn: Authorizations** **PO Box 4004** **Bothell, WA 98041-4004**

Providers are encouraged to use the Molina Healthcare WebPortal for prior authorization submission. When submitting a request for outpatient services we have a rules based authorization submission process called Clear Coverage. When you log into the WebPortal choose the drop down option "Create Service Request/Authorization using Clear Coverage" link under the Service Request/Authorization Menu. Currently the rules based authorization submission process is for outpatient services.

Some of the benefits of using Clear Coverage are:

- Many outpatient services can automatically be approved at the time of the authorization submission
- For requests not automatically approved, you can see the real-time status of your request by opening your office's home page directly in *Clear Coverage*
- Receive rapid confirmation for services where no authorization is required. You are notified within a few steps if no authorization is required for the CPT code requested. You can print or paste a copy of that notification showing no authorization required for your records. There is no need for you to take any additional action.

If you need confirmation that no authorization is needed use Clear Coverage for validation instead of faxing the request

We have included in the Forms section of this manual a copy of the current Prior Authorization Form. If using a different form, the Provider is required to supply the following information, as applicable, for the requested service:

- Member demographic information (name, date of birth, social security number, etc.)
- Provider demographic information (referring Provider and referred specialist)
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (ICD-9 Code and description)
- Clinical indications necessitating service or referral
- Pertinent medical history and treatment, laboratory data, and/or physical exams that address the area of request
- Location where the service will be performed
- Requested length of stay (inpatient requests)

Pertinent data and information is required by the UM staff to enable a thorough assessment for medical necessity and assign appropriate diagnosis and procedure codes to the authorization. Authorization is based on verification of Member eligibility and benefit coverage at the time of service.

Molina Healthcare will process any "non-urgent" requests within five working days. "Urgent" requests will be processed within one working day. If a referral has been previously approved, the specialist or vendor may call Molina Healthcare directly to request an extension of services. Information generally required to support the decision-making process includes:

- Adequate patient history related to the requested services
- Physical examination that addresses the area of the request
- Supporting lab and/or X-ray results to support the request
- Relevant PCP and/or Specialist progress notes or consultations
- Any other relevant information or data specific to the request

Providers should send requests for code changes of prior authorizations to the Healthcare Services Department by phone, fax, or mail, based on the urgency of the requested service. Contact information is listed below.

Phone: **(800) 869-7185**
Fax: **(800) 767-7188**
Mail: **Molina Healthcare of Washington, Inc.**
Attn: Authorizations
PO Box 4004
Bothell, WA 98041-4004

Requests for code changes to previously submitted requests will be handled in the same manner and by the same time frames as prior auth requests. Providers are encouraged to use the Molina Healthcare Prior Authorization Form to request any code change. If using a different form, the Provider is required to supply the following information, as applicable, for the requested service:

- Member demographic information (name, date of birth, social security number, etc.)
- Provider demographic information (referring Provider and referred specialist)
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (ICD-9 Code and description)
- Clinical indications necessitating service or referral
- Pertinent medical history and treatment, laboratory data, and/or physical exams that address the area of request
- Location where the service will be performed
- Requested length of stay (inpatient requests)

Pertinent data and information is required by the UM staff to enable a thorough assessment for medical necessity and assign appropriate diagnosis and procedure codes to the authorization. Authorization is based on verification of Member eligibility and benefit coverage at the time of service.

When a service request is denied a phone call attempt is made to the ordering provider to communicate the denial and the reason for the denial. It is followed with written notification within three (3) days of the denial to the referring provider, Member's PCP and the Member.

Cancellation of Prior Authorized Services: Due to WAC 284-43-410, Molina Healthcare has implemented a process of canceling prior authorized services if the Member has lost eligibility. Molina Healthcare's process is as follows:

1. Molina Healthcare limits the authorization time frame to the current calendar month (i.e., all services will need to be rendered during the calendar month in which the authorization is issued); or
2. Molina Healthcare sends a written notice that a Member's eligibility will be terminating at the end of a given month, and any previously issued authorization(s) will be cancelled as of the last day of the month if services are not rendered by the last day of the month. This notice is sent to the rendering Provider, Member's PCP and the Member.

Second Medical/Surgical Opinion: A Member may request a second medical/surgical opinion at any time during the course of a particular treatment, in the following manner:

- Molina Healthcare Members may request a second opinion about the care they are receiving at any time.
- The member may request the Second Opinion through their assigned PCP or through Molina HealthCare's Member Service Department.

- Second opinion consultations with participating practitioners, arranged by the member's PCP, do not require review or prior approval by Molina Healthcare.

- A Member Services representative can assist the Member in coordinating the second opinion request with the Member's PCP, specialist and/or medical group/IPA.

- An approval to a non-participating Provider will be facilitated by Molina Healthcare or the medical group/IPA if the requested specialty care Provider or service is not available within the Molina Healthcare network.

- The Medical Director may request a second opinion at any time on any case deemed to require specialty Provider advisor review.

Providers who request prior authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting Provider at (425) 424-1100 or (800) 869-7175.

Wrong Site Surgery: If it is determined a wrong site surgery was performed, Molina Healthcare will not reimburse the providers responsible for the error.

AVOIDING CONFLICT OF INTEREST

This is something we want to reassure you of every year.

The UM Department affirms its decision-making is based on appropriateness of care and service and the existence of benefit coverage.

Molina Healthcare does not reward Providers or other individuals for issuing denials of coverage or care. Furthermore, Molina Healthcare never provides financial incentives to encourage UM decision makers to make determinations that result in under-utilization.

Also, we require our delegated medical groups/IPAs to avoid this kind of conflict of interest.

COORDINATION OF CARE

Molina Healthcare of WA, Utilization Management, Case Management and QI will work with providers to assist with coordinating services and benefits for members with complex needs and issues. It is the responsibility of contracted providers to assess members and with the participation of the member and their representatives, create a treatment care plan. The treatment plan is to be documented in the medical record and is updated as conditions and needs change.

MHW staff assists providers by identifying needs and issues that may not be verbalized by providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by MHW staff is done in partnership with providers and members to ensure efforts are efficient and non-duplicative.

CONTINUITY OF CARE

Molina Healthcare Members involved in an "active course of treatment" have the option to complete that treatment with the Provider who initiated the care. The lack of a contract with the Provider of a new Member or terminated contracts between Molina Healthcare and a Provider will not interfere with this option. This option includes the following Members who are:

- In the second or third trimester of pregnancy
- Receiving care for an acute medical condition
- Receiving care for an acute episode of a chronic condition

For each Member identified in the categories above, Molina Healthcare will work with the treating Provider on a transition plan over a reasonable period of time. Each case will be individualized to meet the Member's needs.

Requests for continued care should be submitted to the Healthcare Services Department at the phone number and address listed at the beginning of this section on page 6-1. All requests will be reviewed by the Medical Director. Molina Healthcare will not approve continued care by a non-participating Provider if:

- The Member only requires monitoring of a chronic condition
- The Provider does not qualify for Molina Healthcare credentialing based on a previous professional review action
- The Provider is unwilling to continue care for the Member

CONTINUITY AND COORDINATION OF PROVIDER COMMUNICATION

Molina Healthcare stresses the importance of timely communication between Providers involved in a Member's care. This is especially critical between specialists, including mental health Providers and the Member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

CASE MANAGEMENT

Molina Healthcare provides a comprehensive Case Management (CM) program to all Members who meet the criteria for services. CM focuses on procuring and coordinating the care, services, and resources needed by Members with complex issues through a continuum of care. Public Health issues are comprehensively managed through CM. Molina Healthcare adheres to Case Management Society of America (CMSA) Standards of Practice Guidelines in its execution of the program.

The Molina Healthcare Case Managers are licensed Registered Nurses (RNs) and are educated, trained and experienced in the case management process. The CM program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes.

CM is individualized to accommodate a Member's needs with collaboration and approval from the Member's PCP. The Molina Healthcare Case Manager will arrange individual services for Members whose needs include ongoing medical care, home health care, hospice care, rehabilitation services, and preventive services. The Molina Healthcare Case Manager is responsible for assessing the Member's appropriateness for the CM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

Referral to Case Management: Members with high-risk medical conditions may be referred by their PCP or specialty care Provider to the CM program. The Case Manager works collaboratively with all Members of the health care team, including the PCP, hospital UM staff, discharge planners, specialist Providers, ancillary Providers, the local Health Department and other community resources. The referral source provides the Case Manager with demographic, health care and social data about the Member being referred.

Members with the following conditions are potential cases and should be referred to the Molina Healthcare CM Program for evaluation:

- High-risk pregnancy
- Catastrophic medical conditions (e.g. HIV, neoplasms, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, ESRD)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing ER services inappropriately
- CSHCN

Referrals to the CM program may be made by contacting Molina Healthcare at:

Phone: (800) 869-7185 Fax: (800) 767-7188

PCP Responsibilities in Case Management Referrals: The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The Case Manager provides the PCP with reports, updates, and information regarding the Member's progress through the case management plan. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

Case Manager Responsibilities: The Case Manager collaborates with all resources involved and develops a plan of care which includes a multidisciplinary action plan (team treatment plan), a link to the appropriate institutional and community resources, and a statement of expected outcomes. Jointly, the Case Manager, Providers, and the Member are responsible for implementing the plan of care. Additionally the Case Manager:

- Monitors and communicates the progress of the implemented plan of care to all involved resources
- Serves as a coordinator and resource to team members throughout the implementation of the plan, and makes revisions to the plan as suggested and needed
- Coordinates appropriate education and encourages the Member's role in self-help
- Monitors progress toward the Member's achievement of treatment plan goals in order to determine an appropriate time for the Member's discharge from the CM program

Health Education and Preventive Care Programs: Molina Healthcare's Health Education and Health Management programs will be incorporated into the Member's treatment plan to address the Member's health care needs. Primary prevention programs may include nutrition, exercise, smoking cessation, stress reduction and wellness. Case Managers will work closely with the Health Education staff to coordinate in-service education services.

Supplemental Security Income (SSI) Eligibility: Case Managers also identify Members who may be eligible for SSI benefits and refer them to Molina Healthcare's SSI Coordinator to assist them with the SSI application process. Once a Member is approved for SSI, they are no longer eligible for managed care. See section 2, page 6 for more details on SSI.

TRANSITIONAL CARE PROGRAM

During episodes of illness involving multiple care settings, members are at increased risk of poor health outcomes and avoidable re-admissions resulting from fragmented care if care transitions are not well executed. Molina designed its patient-centered Transitional Care program to improve the quality of care for members with complex physical, long-term, and behavioral health care needs as they transition across care settings. Transitional Care programs have been shown to reduce preventable readmissions and Emergency Department use.

Molina defines Transitional Care to include all services required to ensure the coordination and continuity of care from one care setting to another as the member's health status changes. This includes members discharging from medical, psychiatric and chemical dependency inpatient treatment facilities. During care transitions, Molina's Transitional Care team will confirm and reestablish the member's connection to their medical home and assist in the movement of the member from one care setting to another. The target population for Molina's Transitional Care program are members at high risk of re-admission, based on medical literature and 30 years of experience serving the Medicaid population. These include members with a diagnosis of:

- Asthma
- Cellulitis
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Diabetes
- Pneumonia
- Chronic mental illness
- Substance abuse disorder

Additional secondary criteria will be considered based on acuity and may include, but are not limited to, the following:

- Member history of re-admission and poor adherence to follow-up treatment
- Alzheimer's disease
- Parkinson's disease
- Multiple co-morbid conditions

Members are initially contacted by a Transitional Care Coach via a face-to-face visit while in the inpatient setting. If members consent to participate in the Transitional Care program, work begins to develop an individual care transition plan and personal health record. Following discharge, the member receives a follow-up phone call within 2-3 days after discharge, and a face-to-face visit in their place of residence within one week after discharge. During these contacts, the individual transitional care plan and personal health record are completed and implemented. The Transitional Care staff will assess the safety of the environment, the member's support network and community connections, and will assist the member with obtaining other immediate psychosocial needs such as food, transportation, clothing, social support, advocacy, and other community-based resources.

The Transitional Care Coach will continue to provide care coordination for up to 6 weeks, primarily via telephone, to ensure that the goals of the individual transitional care plan have been met and a member has successfully transitioned to a lower level of care. As the transitional care process nears completion, Molina's Transitional Care staff will identify any on-going needs that a member may have and, if needed, coordinate a referral to the Molina Case Management program or PCP who will work with the member to address those needs going forward.

Molina has developed operational agreements with Regional Support Networks, targeted substance use disorder treatment facilities, long-term care facilities, and behavioral and physical health facilities to communicate and collaborate on members' transitions through different levels of care. These operational agreements include guidelines for sharing the following information:

- Notification to Molina and PCP of member admission
- Written discharge plan provided to both the member and PCP
- Discharge planning including scheduled follow-up visits
- Coordination of services needed upon discharge
- Notification to Molina and PCP of discharge

When warranted for HIPAA compliance, Molina will obtain releases from members to allow sharing of data.

CVS CAREMARK Specialty Pharmacy

In an effort to offer enhanced services, Molina Healthcare has entered into a relationship with CVS/Caremark Specialty Pharmacy to provide an innovative injectable drug delivery program. This service eliminates the cost associated with stocking and billing for office administered specialty injectable drugs for Molina Healthcare Members.

CVS/Caremark Specialty Pharmacy operates as a business unit within CVS/Caremark Corporation. The Member and Provider dispensing capabilities of McKesson Specialty Pharmaceuticals complement McKesson's existing patient relationship and disease management businesses, which hold market-leading positions.

Some of the specialty injectable drugs provided by CVS/Caremark Specialty Pharmacy are:

- Remicade
- Enbrel
- Lupron
- Interferons
- Plus many others

When a Molina Healthcare Member needs an injectable medication, the prescription can be submitted to Molina Healthcare by fax at 1-800869-7791. Specialized request forms can be obtained by calling 800-237-2767 or at http://www.molinahealthcare.com/medicaid/providers/wa/pdf/specialty%20drug%20request%20form.pdf?E=true

CVS/Caremark Specialty Pharmacy will coordinate with Molina Healthcare and ship the prescription directly to your office or the Member's home. All packages are individually marked for each patient, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge.

Please contact your Provider Relations Representative with any further questions about the program.